

MEMORANDUM

DATE: October 31, 2007

TO: Ms. Sharon L. Summers, DMMA
Planning and Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 11 DE Reg. 442 [Acquired Brain Injury Waiver]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA) Acquired Brain Injury (ABI) Waiver application published as 11 DE Reg. 442 in the October 1, 2007 issue of the Register of Regulations. As background, SCPD has been very involved in development of an ABI waiver. In the past, DHSS had secured CMS approval of an ABI waiver which it later abandoned based on an inability to secure providers. DHSS then attempted to have existing waivers amended to address the specific needs of persons with ABI. This initiative was abandoned in the Spring based on CMS lack of receptivity. Since then, DHSS has worked on development of a new ABI waiver. The SCPD has offered technical assistance to support renewed development of the waiver which will be effective December 1, 2007. SCPD has the following observations.

First, the overall program is "provider-based" and adopts a commercial-provider services model. Unlike the attendant services program, participant direction of services is not an option. [Application:5; Appendix E-1:1] Since the services are more varied than attendant services, there may be some justification for adopting this approach in the initial 3-year waiver period.

Second, some positive aspects of the waiver include consumer choice of providers [Application: 8; Appendix B-7:1] and an individual service plan which covers wrap-around services, not simply those under the waiver program [Application: 7; Appendix D-1:4].

Third, there is an MOU between DSAAPD and DMMA, signed in July of 2007, which describes

agency collaboration in implementing the waiver. [Appendix A:1; Appendix H:3]. SCPD respectfully requests a copy of the MOU.

Fourth, the quality assurance system is relatively strong in the context of number of cases reviewed. A DSAAPD nurse will review 100% of initial case plans. [Appendix A:4; Appendix D-1:7]. DMMA will conduct retrospective review of 25% of ABI care plans. [Appendix A:2; Appendix D-1:7]. The latter review will be a “desk audit to ensure completion in accordance with all applicable ABI policies and procedures.” Nurses will meet participants and review records of participants in AL facilities 3-4 times/year. [Appendix G-3:2] The weakness with this system is its lack of consumer surveys akin to the attendant services program. Reviewing paperwork will not result in identification of some deficiencies and diminishes the importance of consumer views of the responsiveness of the program to their needs.

Fifth, although there is a minimum age limit (age 18), there is no maximum age limit. [Appendix B-1:1. SCPD endorses this provision since many of the individuals in the E&D waiver will be elderly.

Sixth, there is a problematic statement at Appendix B-1:2. DMMA recites as follows:

The ABI Care Plan for participants in the waiver must demonstrate that the ABI waiver participant would benefit from ABI case management and at least one other ABI waiver services...that are not available in another waiver.

[emphasis supplied]. This may be an unnecessary restriction. It means that a person living outside an assisted living setting who seeks only personal care, respite, and a personal emergency response system would not qualify for the ABI waiver.

Seventh,, apart from the requirement that a waiver participant meet a nursing level of care [Application: 2; Appendix B-6:2], DMMA imposes a severity test. A participant must “have a rating of at least 5 but not greater than 8 on the Rancho Los Amigos Level of Cognitive Functioning Scale. Attached is a copy of the Scale. One could argue that a person at Level IX could still benefit from waiver services.

Eighth, an aggregate rather than an individual cost cap is used in this waiver. [Appendix B-2:1; Appendix C-4:1]. SCPD endorses this provision.

Ninth, in the first year, up to 50 individuals may participate in the waiver. This would increase to 60 individuals in Year 2 and to 70 individuals in Year 3. [Appendix B-3:1] There is no prioritization based on current institutionalization, applicants in crisis, or geographical location. [Appendix B-3:2] If the waiver reaches capacity (50 persons in Year 1), a waiting list would be developed. First priority for the waiting list would be given to E&D and AL waiver participants. Second priority for the waiting list would be given to non-participants in the E&D and AL waivers. There is obviously a “cost” aspect to this prioritization since the State will spend less by transferring persons in an existing waiver to a new waiver. However, DHSS could consider whether some variation of this prioritization would be

preferable. For example, if an individual with TBI is homeless and “in crisis”, it may make sense to prioritize such an individual over someone receiving supports under an existing waiver. Alternatively, this population could be identified as a priority under the “second priority” criteria which is provided to non- participants in the E&D and AL waivers.

Tenth, financial eligibility is limited to individuals with countable income under 250% of the federal benefit rate (FBR). [Appendix B-4:2] Consistent with the attachment, the FBR for an individual in 2007 is \$623 and 250% of the FBR would be \$1,557.50. SCPD recommends that DMMA adopt a 300% of FBR standard which would equate to \$1,869/month in countable income.

Eleventh, DMMA requires a participant to require at least 1 waiver service apart from case management on a monthly basis. DMMA did not adopt the option of “monthly monitoring of the individual when services are furnished on a less than monthly basis”. The problem with this approach has been debated in the context of the DD waiver. Under that waiver, individuals who are very elderly (80), recovering post-hospitalization, or diagnosed with cancer with 4 months to live still must attend a day program or lose waiver eligibility. If an ABI waiver participant cannot attend Enhanced Level II day services or day habilitation due to illness or other cause, DMMA unnecessarily restricts its discretion to maintain the person’s waiver eligibility.

Twelfth, the menu of services is as follows: 1) case management; 2) personal care; 3) adult day health; 4) day habilitation; 5) respite; 6) day treatment (cognitive treatment); 7) personal emergency response system; and 8) assisted living. [Appendix C-1:1] The scope of some of these services is not intuitive. For example, the waiver does not cover room and board for assisted living. [Appendix C-2:3] Rather, it covers only the cost (approximately \$37.17 to 64.76 daily) of some enhanced services. [Appendix I-2:1; Appendix J-2:2; Appendix J-2:7] As a practical matter, this may exclude participation in the waiver by many assisted living residents. Query how many individuals will be financially able to pay approximately \$36,000 for assisted living base costs when they can only have countable income of 250% of the FBL (\$1,557.50)? Moreover, many AL facilities already provide the contemplated enhanced services, including “prompting”. [Appendix C-3:3]. See, e.g., attached rate levels for sample AL facility (Somerford). Forty percent (40%) of waiver participants are expected to receive AL services. [Appendix J-2: 2] DMMA suggests that State funds might be used for room and board, but it is unclear if such funds are included in the DHSS budget. [Appendix I-5:1]

Thirteenth, DMMA had the option of allowing relatives to provide waiver services. However, it did not exercise this option for any service. [Appendix C-2:4; Appendix C-3:3; Appendix C-3:7; Appendix C-3: 11; Appendix C-3:13; and Appendix C-3:15]. This is objectionable. At least in the contexts of respite and personal care services, relatives should be authorized providers. Compare attached DDDS respite policy, which recites as follows:

O. Natural families may identify a family member or other individual (at least 18 years of age) whom they feel is appropriate to provide private respite for their family member. It shall be the responsibility of the family to insure that the said private provider is competent to provide adequate support to ensure the individual’s health and safety.

Moreover, DHSS recently amended its attendant services program policy to authorize payment of relatives. See attached email which resulted in policy change during summer.

Fourteenth, case management can only be provided by an RN or LCSW. [Appendix C-3:1] This should enhance the quality of services plans. Many organizations use case managers with only a bachelor's degree.

Fifteenth, the waiver includes utilization limits. Some of these limits are odd. For example, the limit for both adult day services and day habilitation is 4 days per week. [Appendix C-3:5; Appendix C-3:7] It is inferable that most individuals attending day programs attend 5 days/week. Exceptions are allowed based on case manager requests. Id. In this sense, the limits are more akin to "guidelines". However, it would make sense to establish a guideline of participation in day services and day habilitation of 5 days/week. In the context of "cognitive services" [Appendix C-3:9], DMMA may similarly wish to upgrade the 20 visits/year limit. This equates to only 1.66 counseling visits per month. Other questionable limits apply to personal care services (14 hours/week)[Appendix C-3:11]; and respite (80 hours/year)[Appendix C-3:13]. Parenthetically, the limits may have been set somewhat low to reduce projected costs.

Sixteenth, DMMA recites that the aggregate cost cap is based on "both waiver services and other services." [Appendix C-4:1]. This may not be 100% accurate. Services which are "private pay" or derived from non-Medicaid sources should not be included in the aggregate cap. The expected per participant cost in Year 1 is expected to be \$6,901. [Appendix C-4:2]

Seventeenth, DMMA limits case management to agencies which do not provide services under the individual client plan. [Appendix D-1:1] This reduces the prospects for conflicts of interest in which the case manager "loads up" the plan with its own services. On the other hand, it limits the potential role of a TBI specialty provider which could otherwise offer both an LCSW case manager and counselor.

Eighteenth, the ABI care plan must include back-up plans in the event the regular provider becomes unavailable. [Appendix D-1:6]. SCPD endorses this provision.

Nineteenth, case managers must meet "in-person" with participants at least monthly. [Appendix D-2:1; Appendix D-2:2] SCPD endorses this provision, but also recommends that meetings be at the location where services are being provided.

Twentieth, DSAAPD will refer persons who request a fair hearing to the Community Legal Aid Society, Inc. for assistance. [Appendix F=1:1] SCPD endorses this provision.

Twenty-first, the use of seclusion or restraint is expressly prohibited. [Appendix G-2:1] SCPD endorses this provision.

Twenty-second, DMMA incorrectly recites that administration of medication is limited to medical personnel or personnel who have completed Board of Nursing training. [Appendix G-3:3]. This ignores

a participant's right to self-administer medications; the participant's right to delegate administration to others consistent with Title 24 Del.C. §1921(a)19); and the right of relatives, friends, housekeepers, and servants to administer medications consistent within Title 24 Del.C. §1921(a)(4). See also Title 24 Del.C. §1921(a)(18)[Nurse Practice Act not applicable to attendants acting pursuant to Attendant Services Act].

Twenty-third, estimated costs of the waiver services are compiled at Appendix I-2 and Appendix J-2. Reimbursement rates for some services are actually somewhat high, i.e., respite is \$26.68/hour and personal care is 30.32/hour. This may be a function of the commercial provider bias inherent in the waiver. Note that rate increases may be deferred if State appropriations are insufficient. [Appendix I-2:1]

Twenty-fourth, DMMA recites that the "State does not make supplemental or enhanced payments for waiver services." [Appendix I-3:2] This appears inconsistent with references to payments for supplemental services or additional reimbursement throughout the application. [Appendix C-3:3; Appendix C-3:5]

Finally, the Division anticipates negligible turnover in waiver participants. This is ostensibly a realistic prediction. [Appendix J-2: 1]

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulations.

cc: Mr. Harry Hill
Mr. Guy Perrotti
Ms. Lisa Bond
SCPD Brain Injury Committee
Brain Injury Association of Delaware
Governor's Advisory Council for Exceptional Citizens
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